SKIRBALL HOSPICE
A program of the
Los Angeles Jewish Home

6345 Balboa Blvd., Suite 315
Encino, CA 91316
24 hour phone: 818.774.3040 • Fax: 818.774.3089
www.skirballhospice.org

Election of Hospice Benefit:

I, _____ request admission to Skirball Hospice and elect to receive Hospice Services. I understand and agree to the following:

The Hospice program is palliative, not curative, in goals and treatments. The program emphasizes the relief of symptoms such as pain and physical discomfort and addresses the spiritual needs and the emotional stress which may accompany a life-ending illness or condition.

I am encouraged to participate in the development and implementation of the Hospice Interdisciplinary Plan of Care. I understand Skirball Hospice does not provide 24 hour care or caregivers. I understand I am responsible for having a caregiver provide care to me in my place of residence at my own expense if a family member or other person is not able to provide such care. The caregiver may also participate in decisions about the care provided. The Hospice Interdisciplinary Team supplements rather than replaces care provided by the family or the designated caregiver.

I accept the conditions of SKIRBALL HOSPICE as described, understanding I may choose not to remain in the program and that Hospice may discharge me from the program if hospice care is no longer medically appropriate. I understand however, that if my medical condition changes, I may request to be readmitted at a later date. I have been able to discuss the above conditions with a member of the Hospice staff and have had my questions answered to my satisfaction.

The undersigned Patient or Patient's legally authorized representative hereby consents to any and all examinations and treatments prescribed by Patient's physician (or Hospice physician) rendered by the Agency's licensed nurses, physical therapists, occupational therapists, speech therapists, registered dietitians, social workers, spiritual counselors and home health aides and volunteers.

Skirball Hospice assumes financial responsibility for medications, durable medical equipment and medical supplies related to the terminal illness, approved by Hospice and that are provided by a Hospice approved vendor. I understand that if I chose another vendor, chose medications, equipment and supplies not provided by Hospice through its vendors or authorized by Hospice, I am financially responsible for those charges.

I have the right to direct a pharmacist to dispense a prescription using the brand name my physician prescribes instead of a generic substitution. However, unless I submit a written request to Hospice for brand name prescriptions, I am agreeing the pharmacist that fills my prescription may select the drug product in the Hospice formulary that is generally equivalent to brand name prescribed by my physician.

Hospice Services

Routine Home Care. I understand hospice services are delivered primarily in the home (which may include a nursing home or assisted living facility) provided by a team of hospice professionals, staff and volunteers. These services are available both on a scheduled basis and as needed. I understand that these services may include, as set forth in the hospice plan of care: nursing care, physician care, social work, spiritual, nutrition and bereavement counseling, home health aides, medical supplies, physical therapy, occupational and speech-language therapy and medications prescribed for relief of pain or discomfort.

Inpatient Care / Inpatient Respite Care. I understand inpatient hospice care and inpatient respite care are provided in an inpatient setting when it is deemed necessary by the hospice interdisciplinary team. I understand hospice inpatient care is designed for short-term stays with the goal of stabilizing the patient and family emotionally and physically so the patient can return home. I understand inpatient respite care is designed to provide brief periods of respite for the family or primary caregiver while the patient receives hospice care in an inpatient setting.

Crisis Care (Medicare Continuous Care). I understand that crisis care – meaning extended visits (a minimum of 8 hours of care in a 24 hour period) may be provided in a patient's home or facility when it is deemed necessary by the hospice interdisciplinary team. This extended care is designed for short-term periods to manage acute medical symptoms or a family crisis with the goal of stabilizing the patient's condition or family situation and then returning to Routine Home Care.

I understand that under the Medicare Hospice Benefit, I am entitled to hospice care, which consists of two 90-day periods and subsequent 60-day periods of unlimited duration. For Medi-Cal the benefits are two 90-day periods, a period of 30 days and one subsequent benefit period limited to seven months. At the end of each benefit period, the Hospice Interdisciplinary Team evaluates the patient condition for recertification and for continuation of hospice care.

I understand I am responsible for the cost of care for my terminal illness if I seek care beyond what is considered medically necessary by the hospice interdisciplinary group and documented on my plan of care.

I understand I may revoke the hospice benefit at any time by signing a statement to that effect, specifying the date when the revocation is to be effective and submitting the statement to Skirball Hospice prior to that date. This revocation constitutes a waiver of the right to hospice care during the remainder of the current election period.

I understand that once in each election period I may choose to receive services through a hospice program other than SKIRBALL HOSPICE. Such change shall not be considered a revocation of hospice services.

By my signature on page 3 on this document I confirm, verify and acknowledge that the physician I have chosen to serve as my attending physician is:

_____

(Name, First, Last)

_____

(Address, City, State, Zip Code)

_____

(Phone Number)

Advance Directives

I have been provided the following information regarding advance directives.

- ☐ I have the right to formulate an Advance Directive.
- ☐ I am not required to have an Advance Directive in order to receive medical treatment by any healthcare provider.
- ☐ The terms of any Advance Direcive that I have executed and disclosed to Skirball Hospice will be followed to the extent permitted by law.

☐ **The patient has an Advance Directive:**

- ☐ Power of Attorney for Health Care
- ☐ Living Will
- ☐ POLST (Physician Orders for Life Sustaining Treatment)
  - ☐ Check if POLST completed with Hospice election

Name and Address of Agent:

_____

_____

_____

Copy received: ☐ Yes ☐ No

☐ **The patient does not have an Advance Directive.**

Release of Patient Records

I understand SKIRBALL HOSPICE may need to obtain medical records and related information from hospitals, nursing homes, physicians, pharmacies, home health agencies, insurance companies, health care benefit plans or others in order to assure continuity of care and proper reimbursement for services. I authorize the above persons and entities to release to Skirball Hospice and its representatives medical records and related information necessary for the provision of hospice care. I also authorize Skirball Hospice and its representatives to release medical records and related information to others for the purposes of my health care, administration and management of my health care (including utilization review) or processing and obtaining payment for services and supplies rendered to me. I understand and agree that these authorizations specifically include my permission and consent to release any information regarding a diagnosis of AIDS or results of Human Immunodeficiency Virus (HIV) tests to the extent permitted by law. A photocopy of this authorization shall be as valid as the original.

I acknowledge I have received a copy of the SKIRBALL HOSPICE Patient Information Handbook which includes a detailed listing of Patient Rights and Responsibilities and Notice of Privacy Practices.

Acknowledgement

I acknowledge and agree to the terms and conditions described herein:

_____ _____

Signature of Patient — Date

If patient unable to sign, state reason: _____

_____ _____

Signature of Legally Authorized Representative (If Applicable) — Date

_____

Name of Legal Representative (Print) (If Applicable)

_____

Address of Legal Representative (Print) (If Applicable)

_____

Hospice Representative

_____ _____

Patient — MR #